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The Importance of Play to Childhood Development: A Child's Right to Play While Living With HIV/AIDS

Rachel Bambrick
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The Importance of Play to Childhood Development:
A Child's Right to Play While Living With HIV/AIDS

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Date: April 28, 2012

Rachel Bambrick
April 28, 2012
SIT Community Health Spring 2012
Advisor: Yousuf Vaudwa

Abstract:

This is a social analysis paper that explores child development and a child's right to engage in play activities while living with HIV/AIDS in South Africa. Through experiences volunteering at the Children's Rights Centre, interviewing occupational therapy professors, and living and playing in various communities in KwaZulu-Natal, the study looks into play development for children living with HIV and the policies put in place to protect their rights to play and develop. Primary data was triangulated against secondary sources, most of which were found while volunteering at the Children's Rights Centre in Durban. The study looks at the stigmas surrounding HIV/AIDS, as well as its opportunistic infections, and how these work to inhibit a child from engaging in play activities important to their development. This study will be of use to South African people because it will raise awareness of the importance of play to human development, and encourage parents to take a more active role in facilitating play activities for/with their children.

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Introduction:

Due to the fact that I come from an occupational therapy background, I have a great interest in enabling individuals to engage in the activities that they enjoy, regardless of any constraints. As an occupational therapy student, I have already done a lot of work and studying regarding individual empowerment through various aspects of one's life. Through my studying I have become more interested in child development and the influence that something as simple as play has on it.

Developmental theorists, Parten, Vygotsky, and Piaget have done extensive research in the development, with a specific focus on play. Parten and Piaget have categorized types of play into different types and engagement levels. "Parten's Social Play [involves] unoccupied behavior, onlooker behavior, solitary independent play, parallel play (3-4 years), associative play (3-4 years), cooperative/organized supplementary play (4-5 years)" (Germain, 2011), while "Piaget's cognitive view of play [involves] functional (sensorimotor) play, symbolic play (at 4 years this becomes more involved), construction play, games with rules (5 years)" (Germain, 2011). These are levels of play that will typically occur during certain times in a child's development, and there is typically more engagement with others that occurs as the child gets older. For example, a younger child (roughly 2 years old) will be more likely to engage in onlooker behavior or solitary independent play, in which they will only watch other children play, but not engage themselves, or they will play but only with toys by themselves. As children grow and mature, their interactions with others become more common. A five year old child will typically engage in more cooperative/organized supplementary play, in which they will play cooperatively with others, and engage in play activities together, with one common goal. These play development patterns are very important for a child's overall development, as it influences

many aspects of a child's life, and "Vygotsky believes play to be a leading source of development. Play always has rules based on real life" (Germain, 2011).

Upon coming to South Africa, I truly began to realize the full effects of HIV/AIDS on the country. It is an epidemic that is sweeping the nation, and affecting all age groups, cultures, and genders. According to the statistics of the National Strategic Plan on HIV and AIDS, "249,000 children below the age of 15 years were living with HIV in 2006, and over 1 million young people between 15 and 24 years were infected" (Giese, 2009, 15). This number is only growing and more and more children are becoming infected at a young age, as they are still developing. It is important to monitor a child's development, especially if they are living with a chronic disease. I believe that play is a crucial component of child development, but one that is often overlooked, especially in rural communities, where play is typically not encouraged or fostered due to various debilitating factors, such as how far apart houses are spaced, because that inhibits children from other families from interacting with one another, or because the head of the house is a Gogo (granny) and cannot help the child by facilitating play activities because they are too tired or sick. On top of this, HIV in children is preventing children from playing. Stigmas surrounding HIV status, and the opportunistic infections that come with the disease are preventing HIV positive children from engaging in the play activities necessary for their development. The African Charter on the Rights and Welfare of the Child guarantees through Article 12 that, "the child has a right to rest and leisure, to engage in play and recreational activities appropriate to the age of the child, and to participate freely in cultural life and the arts. States and Parties shall respect and promote the right of the child to participate fully in cultural and artistic life and shall encourage the provision of appropriate and equal opportunities for

cultural, artistic, recreational and leisure activity” (African Charter on the Rights and Welfare of the Child Article 12). This article only brings up the question of how realistic this actually is.

This project will explore a child’s right to engage in play activities, as they foster development and increase health. I will explore the topic through a specific lens while looking at the effects that HIV positivity in children has on their rights to participate in play activities that affect their development. I will be looking to see if the disease has a negative effect on play development due to various stigmas and opportunistic infections that come from the disease. While using the Children’s Rights Centre as a base organization I will be able to gain more knowledge while working with experts in the field, and gain more information on child rights to play and specifically in regards to children with HIV/AIDS, as this is one of the main focuses of the NGO, specifically the HIV/AIDS advocacy and communications department, and the play rights department.

Methodologies:

This ISP is based around secondary data triangulated against conversations with Children’s Rights Centre workers and rural community members, interviews with Occupational Therapy professors, and child play observations during homestays (which is categorized based on both Parten and Piaget’s play development models). The data I gained from interviews is also triangulated against play observations I have witnessed and then against secondary data from journals, lectures from my home institution, among other sources.

The methods used include the following;

- 1.Participant observation of children during play activities.
- 2.Participant observation of workers at the Children’s Rights Center
- 3.Participant observation of children in various communities

5. Categorize types of play observed into Parten's Play Stages and Piaget's Types of Play.

Children of certain ages should engage in certain types of play, and they should interact with other children more as they grow older. I used play observations, triangulated against play expectations for children of that age to look for any red flags, that then may be related back to an HIV status and stigmas around it.

6. Categorize types of play and gross and fine motor skills observed in play against typical developmental patterns and stages for children

Participant Observation:

Participant observation took place in the communities I lived in while in homestays; Cato Manor, Impendle, Mtwalume, and Amatikulu. While living in these communities, I observed children playing in countless different places and spaces. The children played games both similar and different to ones played in other communities. While living with families in these communities, I participated in many of the play activities cooperatively with the children, they taught me the rules and allowed me to engage in play with them. I also facilitated play opportunities for the children. The observations were then recorded following play sessions, with all names being kept anonymous, and categorized into Parten's Social View of Play and Piaget's Cognitive View of Play and categorized against childhood developmental stages. Due to the sensitive ethical nature of working with minors, interactions were just observations and no names were recorded or used. Participant observation also took place while volunteering at the Children's Rights Centre. I worked at the centre twice a week for two weeks (4 sessions), doing literature reviews, various office tasks, and working closely with the play rights department. All observations were recorded and participants who I engaged with were given anonymity. Due to

the limited amount of time I was able to spend with the NGO, I was not able to gather much primary information. I used most of my time to research secondary sources from their library.

Expert Interviews:

Two expert interviews took place with occupational therapy professors at two different universities in South Africa. OT1 was interviewed regarding play development in children, the differences between Western and African play, the importance of play in African culture, the importance of play in regards to development, and inhibiting factors for children to engage in play while living with HIV/AIDS. Elelwani Ramugondo, an occupational therapy professor at the University of Cape Town, was interviewed regarding play development, more specifically concerning children living with HIV and the challenges they face when trying to engage in play activities.

Secondary Data:

A majority of the secondary data gathered was found in the library at the Children's Rights Centre, with the help of the play rights department. The data was gathered from journals produced both by Children's Rights Centre workers and other academics. The data also included information from handouts and training manuals used by the CRC at various training sessions for its workers and community members regarding the issues of play, development, and HIV in children. The secondary data was triangulated against my own observations of play and HIV stigmas in various communities and the opinions of expert occupational therapy professors on the topic. Secondary data was also gathered from lectures I received at my home institution in a Human Development I class, taught by professor Amie Germain. The class covered development

in children from birth-late childhood, and play development was a main topic of discussion.

Powerpoint notes and lectures from the class were used to be triangulated against observations and interviews.

Literature Review:

Children's Rights Centre. *My Living Positively Hand-Book*.

This book, produced by the Children's Rights Centre, is a kids friendly book about living with HIV. It is designed to be used and read by kids and their parents. It covers everything from what HIV is, who gets it, to how to take ARVs, all worded for children to understand. The book depicts a lot of what the Children's Rights Centre does, specifically the HIV/AIDS advocacy and communication department. It also demonstrates the importance of teaching children their rights and needs while living with HIV. The book also focuses on the important issue of disclosure.

This is a difficult decision a parent must make; when to tell their child they are HIV-positive, and how to do so. The book suggests methods and gives reasons why parents should tell their children. For example, they suggest that they tell their children a story about the virus, and one story involves describing HIV as a friend that the child will live with forever, but must try and understand and live cooperatively and healthily with. It even includes a chart for children to fill in with spaces to check off when they took their medications and to draw how they felt that day. It is an interactive book that encourages creativity and positive living with HIV for both the child and caregiver.

Giese, S. (2011). *Children's HIV and AIDS Scorecard 2011: Monitoring South Africa's Response to Children and HIV and AIDS*.

This book is an evaluation of how well South Africa is doing on meeting the needs of children with HIV/AIDS, through the lens of the National HIV and AIDS and STI Strategic Plan (NSP). It focuses on 10 key indicators; HIV prevention, infant mortality, child protection, social services, income support, prevention of mother-to-child transmission (PMTCT), access to PMTCT, access to treatment for children, access to treatment for women, and developmental screening. The book looks into the goals set in 2007 by the NSP, involving HIV/AIDS and how they are being met and not met. After presenting the current data on South Africa's progress towards preventing HIV/AIDS in children, the book summarizes the progress in a chart that demonstrates whether or not South Africa is on target to meet the NSP targets for 2011 (some for 2015). It is presented in an easy to read format, and depicts many of the statistics in the form of charts, graphs, and diagrams. The book is a good tool to use to get a general understanding of the progress, or lack thereof, that South Africa has made regarding HIV infection in children.

Children's Rights Centre. (2007). *Helping Children Living with HIV*.

This is a companion book to, *My Living Positively Hand-Book*. It takes a more parental or caregiver perspective. It was designed to teach caregivers how to use the hand-book in an effective manner. It also works to teach caregivers about the importance of talking to children about HIV, with suggestions about what to talk about and when. It is a good book to get a different perspective, that of the caregivers, which is crucial when trying to understand children. It again demonstrates what the Children's Rights Centre works to produce and get out to the community. This book is meant to be distributed to the community to inform parents and guardians and enable children living with HIV to live positively and receive the care they need.

Child-to-Child Trust. (2004). *Early Years Children Promote Health: Case Studies on Child-to-Child and Early Childhood Development*.

This book, produced by the Child-to-Child Trust evaluates programs put in place by the trust in various countries across the globe, from Brazil to Uganda. The Child-to-Child Trust works to implement programs in countries of need that emphasize the role that older children play in promoting the physical and mental health of younger children. They work to empower older children and give them training and power to be community leaders. While presenting case studies from programs implemented in various communities across the globe, the book covers various issues regarding child development. It categorizes development into psychosocial, physical, and cognitive patterns. It also emphasizes the importance of play in child development, specifically involving the need for children to be stimulated in their home environments. The book looks at both urban and rural play and discusses the difficulties that children face in each setting, and provides reasons why children may or may not be able to engage in play (tired caregivers, unsafe facilities, lack of play materials, etc). It also touches on the importance of children to play if they are sick or living with a chronic illness, as it boosts their morale and improves their mental health.

Children's Rights Project. (2000). Rights for our children. *Resource Manual*.

This manual is designed to be a teaching tool for program facilitators at the Children's Rights Centre. It is a 1,000 page manual that first gives examples of programs facilitators could run in various communities regarding children's rights. For example, one page has cut-out cards, with each depicting a different right guaranteed to children in South Africa. The second half of the

manual covers children's rights in more detail. It goes over policies and charters put in place both in South Africa and the World. It covers The United Nations Convention on The Rights of the Child (1989), The World Summit For Children (1990), and The Organisation of African Unity African Charter on the Rights and Welfare of the Child, among others. It then relates these rights back to South Africa, and legislation put in place in the country, both through the South African Constitution Article 28 of the Bill of Rights and The Children's Charter. The manual is then divided into categories of children's rights, covering everything from the right to access health care to the right to access education to the right to participate in play and leisure activities. It discusses the rights of children living with HIV/AIDS and their rights to not be discriminated against. It is an excellent resource put together by the Children's Rights Project both for program facilitators and for the general public to inform them of rights guaranteed to children.

Findings and Analysis:

Human Development Theory:

Humans are constantly developing and changing throughout their lifespan. They are always growing, changing, and adapting. There are five main perspectives on development; psychoanalytic, learning, cognitive, ethological, and contextual (Germain, 2011). It is believed by various developmental theorists that people develop through one of these perspectives, when in reality humans change and grow under each of these perspectives. Psychoanalytic development theorists believe that individuals change due to unconscious forces that motivate human behavior, learning theorists state that people develop based on watching role models and growing by copying what the role models do, cognitive theorists believe that people develop based on reflection and intricate thought processes, ethological theorists state that people develop

due to evolutionary behavior changes, and contextual theorists believe that an individual cannot be separated from their environment and a person's surrounding environment and context are directly responsible for their development (Germain, 2011). While these theorists all have different opinions on what causes human development, all of these theories are actually working together to produce an accurate depiction of human development.

Developmental Stages for Children:

Development begins in the womb, immediately following conception and continues on through an individual's life until death, but the most important time for development is childhood. During this time period, an individual is going through the most changes and everything that takes place in their lives has the ability to directly influence their lives and development forever. Human development can be divided into three categories; physical, cognitive, and psychosocial. Physical development in children covers everything from the progression from sitting to walking to the fine motor skill of being able to hold a pencil and begin writing. Cognitive development covers speech, as well as thought progression and memory development. Psychosocial development deals with how children interact with others, whether they are peers, teachers, parents, etc and how they build relationships. The development stages for children are; pre-birth, babies and toddlers (birth-18-24 months), early childhood (3-5 years), middle childhood (6-10 years), and late childhood (10-13 years) (Germain, 2011). Children grow and develop at a rapid rate, and they are easily imprinted on, almost everything that happens to them influences their development in some form or another. "Early childhood experiences are critical because deficiencies at this age may have lasting effects" (Powell, 2007, p. 2). Childhood is a crucial developmental stage, and all adult figures in a child's life must take this into account while raising the child.

The Importance of Play to Development:

Children are constantly playing in various places and spaces and with a variety of play things. Play seems like something that comes naturally to children, but people may not know that it is a crucial aspect to their development. Play affects each area of development; physical, cognitive, and psychosocial. It “is a leading source of development...[and] always has rules based on real life” (Germain, 2011). It sets foundations for how children will act later in life, “playing with children is not only for purposes of recreation, but...can teach them a lot of skills and concepts about life” (Salvation Army-Masiye Camp, p. 54). By engaging in play, children work on fine and gross motor skills, cognitive function, and learn how to build relationships and interact with peers. “Children will also show their feelings in the way they play, and this is good for them. If you watch them play, you will understand their lives better and be able to help them (Ramsden & Vawda, 2007, p. 21). It is similar to a therapeutic exercise in the sense that it gives children a chance to express themselves without actually realizing it. It is important for people to understand that, “all children need to be active. They like to run and to play tag. They like to climb and slide, to swing and jump. This kind of play is not a waste of time” (Child-to-Child Trust, 2004, p. 165). Many adults brush play off without realizing the great importance it holds for child development, and in order to “facilitate children’s play, so that children can derive most benefit from it, adults need to be sympathetic and to understand children and their needs. They must have an understanding of the developmental ages and stages that children go through, and how their play needs to change as they grow and develop” (Sharon, p. 2). Occupational therapy (OT) professor teaching at a Durban university spoke on play development by saying, “Of course play is essential for development” (OT1, personal communication, March 2012). It seemed to be a silly question to ask, based on her response, because she thought the answer should have been

obvious. Elelwani Ramugondo, an OT professor from Cape Town was also quoted in the Mail & Guardian as saying, “If a child is not encouraged to play, it might as well not eat. It’s extremely important for development” (Ramugondo, 2012). Play and active participation in play activities need to be fostered in order for a child to develop properly.

Types of Play:

Play is “categorized by; content, what the child is doing when playing, and social dimension; if the child is playing alone or with others” (Germain, 2011). More specifically, there has been work done by developmental theorists in categorizing types of play based on both its cognitive and social aspects. Parten’s Social Play view categorizes play by how children interact with others at different ages and stages in their development. It is organized by age; unoccupied behavior, onlooker behavior, solitary independent play, parallel play (3-4 years), associative play (3-4 years), cooperative/organized supplementary play (4-5 years) (Germain, 2011). Unoccupied behavior is the earliest stage of social play. A child engaging in unoccupied behavior would sit on their own, not engaging with their environment, toys, or those around them. Onlooker behavior occurs when the child is in a group setting with other children, and he/she watches the other children interact and play, but always from a distance, he/she never interacts or engages with the other kids. In solitary independent play the child plays by his or herself, with a toy or their environment, but doesn’t interact with their environment. This could include playing alone with a doll, truck, etc. Parallel play occurs more often as the child matures, and typically starts around the age of three. The child will play alongside peers, but will not interact with them. For example, if two children were playing in a sandbox together, they would each be building sandcastles on their own and not acknowledging the other. They are doing the same activity, but completely separately. As the child develops and grows, play becomes more interactive with

peers. In associative play, children play together and engage with one another in play activities. They will interact with one another and play the same games, but will not be working for one outcome or common goal in their play. Finally, in cooperative/organized supplementary play children play games together with one common end goal. For example, they could all be playing with blocks with the common goal to build the highest tower possible. They are cooperatively working and interacting to produce one final product.

Piaget's Cognitive View of Play takes a slightly different approach to categorizing play stages by age and development. This view categorizes play based on the types of activities children are engaging in and their links to the child's cognitive function. The stages of Piaget's Cognitive View of Play include; functional (sensorimotor) play, symbolic play (at 4 years this becomes more involved), construction play, games with rules (5 years) (Germain, 2011).

Functional, or sensorimotor play describes play that involves heavy gross motor work and sensory input for the child. It engages their senses and motor skills on many different levels. Types of functional play include, racing, climbing, jumping, playing hop-scotch, among many other high intensity sensorimotor activities. Symbolic play is often referred to as "pretend play" because it is exactly that. It involves children acting out scenarios for various play situations or games. This includes; playing doctor and operating on a teddy bear or playing house and being mama for the other children, to name a few. It engages the child's imagination as they take on various roles and act out situations they would not typically be allowed to engage in.

Construction play is exactly what one would imagine. It involves building and creating through play. Examples of this type of play include; building with blocks, finger painting, drawing, folding origami, etc. It is any type of play that is done to create something that the child has constructed. Finally, games with rules is the type of play that occurs last in a child's play

development. It also calls upon Parten's stage of social play, cooperative/organized supplementary play, and children typically do not begin to engage in games with rules until they are about five years old. Games with rules can include everything from organized sport, like soccer, to setting up an obstacle course with rules and tasks at each station. As the reader may be able to notice, many of these stages overlap with one another and it is hard to classify types of play exclusively. For example, a game of hop-scotch could be covered by both functional play and games with rules. The categorization is not meant to be exclusive, but rather to examine the child's cognitive development through play.

Participant Observations:

While living in and engaging with various communities in Durban, KwaZulu-Natal, South Africa, I had the unique opportunity to play with children in countless spaces and places. The types of play activities that children created without the use of toys or conventional play equipment was remarkable. During my time spent in Cato Manor, a township of Durban, I spent a lot of time playing with the children at the community grounds. I was then able to observe and participate in the play activities with the children and categorize them based on Parten and Piaget's theories on play. These were my recorded observations:

“Play is a huge part of every day life for the children. Soccer is a big organized game with rules play type for older children (observed onlooker behavior from younger children). Not much solitary independent play, most children interact. Dramatic play observed while playing “House” or “Gogo” (don't let Granny catch you). Skipping rope commonly played, demonstrates constructive, functional, and games with rules play types. Activities observed: soccer, skipping rope, tag, frisbee, puzzles, cards, coloring, hopscotch, and basketball. There is a high social

capita among the children in Cato Manor. They are always playing and interacting with each other” (Bambrick, personal observation, February 2012).

Their play activities generally centered around functional play and games with rules. The play engaged a lot of their gross motor skills, like running, skipping, jumping, etc. It was extremely active, and for the older children almost always revolved around one game with rules; soccer. Most of the children I observed were very engaged, and doing activities appropriate to their age. The younger children were demonstrating onlooker behavior, while they watched the other children play organized games. The only atypical behavior that I observed came through the observation that many younger children were engaging in activities a bit early for their developmental stages. Many tried to engage in cooperative/organized supplementary play with the older children, when they should have been engaging in parallel play with children their age. This may be because of a universal desire to act older than ones age, or it could be because they do not have adult supervisors when playing to instruct them to play more appropriate activities for their age, but an accurate conclusion cannot be drawn from this observation.

I also had the opportunity to observe and engage in play activities at a preschool funded by Noah’s Ark. Noah’s Ark is a non-government organization that helps fund and set-up schools and orphanages for children affected by HIV/AIDS. Noah’s Ark helps to start the spaces, but then leaves it up to the community to keep them running. I spent 4 hours at the preschool engaging with children of preschool age, roughly 3-5 years. Their day was filled with opportunities for play activities, and the children certainly capitalized on that. My recorded observations of the day were as follows:

“They engaged in play activities throughout the day. The day began with song and dance (functional play) intermittent with learning about the days of the week,

weather, etc. The rest of the day was spent doing various play activities. Coloring (constructive play), playing kitchen (dramatic play), playing with dolls (dramatic play), clay work (constructive play), and outside on the playground (functional play). A majority of the children engaged in all of the activities associatively and cooperative supplementary play. A few of the children engaged in solitary independent play and onlooker behavior. The children were at an age where they should be engaging with others, and most of them were, but not all” (Bambrick, personal observation, February 2012).

As one can tell, the children were given the opportunity to engage in play that covered almost all of Piaget’s cognitive types of play, and many took advantage of this. They also followed Parten’s social play guidelines, in the fact that most were actively engaging in play with others, whether associatively or cooperatively. There were a few children demonstrating onlooker behavior and solitary independent play, which is typically ending around this stage in their lives, but this is not necessarily a cause for concern because all children develop slightly differently. It would be concerning if these children were a 2-3 years older and still engaging in onlooker behavior in their play. Children developing slower than their peers need to be watched as their development progresses, but if they are not too far behind it is not an immediate concern.

Differences Between Western Play and African Play:

One must keep in mind that Parten and Piaget designed their play categorizations around a Western model of play in children. I have also categorized the play activities of the children I observed based on these typically Western models. Though play is a universal concept for children, the ways in which children participate in it is not necessarily universal. The differences between Western and African play need to be addressed. Children living in with a high socioeconomic status in South Africa “participate in most everything that Western children do.

Based on their socioeconomic status, they can have all the toys and technology that Western children do” (OT1, personal communication, March 2012). The differences come as we look at children living in lower socioeconomic statuses and in more rural areas. This is when their context has a huge influence on how, where, and when they are able to play. OT1 remarked that, “kids from lower socioeconomic statuses don’t have the economic resources to buy play goods, and their lives also follow a different structure” (OT1, personal communication, March 2012). They have to be more creative with the play goods they can use. For example, while living in the rural area of Amatikulu, about 1 hour south of Durban, the children used bunches of plastic bags rolled up inside each other to create a ball to play soccer with (Bambrick, personal observation, March 2012). Their lives also follow a very different structure from the lives of many children of higher socioeconomic statuses, because “chores and housework are more important in rural areas, and play then becomes infused with chores because it’s a common task in their lives. The value of play in different cultures is very different, children’s roles influence the types of play” (OT1, personal communication, March 2012). Children living in rural South African areas typically play a larger role in helping around the house. This therefore leads to children having very specific times when play is allowed because it is not time for chores. The children also integrate play into their daily chores. In rural communities, “The idea of play or learning through play isn’t traditionally an accepted idea” (Karlsson, SIT lecture series, February 2012). Parten and Piaget’s play types were based around Western models of play, in which many children have the ability to access adequate play equipment and safe play spaces. This is not necessarily true for children in both Western society and African society. One must take this into consideration when categorizing play. Though my observations were made and recorded, they must be taken with a grain of salt.

Development and Play Rights for Children:

Childhood development, and development through the lens of play is clearly very important in a child's early years, but how can it be ensured that children in South Africa are able to play and develop? There are charters and laws put in place, both by South African government and the United Nations to protect the rights of children, and these rights include the right to play and the right to develop. The United Nations Convention on the Rights of the Child (1989) declared that, "the child has the right to leisure, play, and participation in culture and artistic activities" (Children's Rights Project, 2000, p. 227). This was a universal declaration declaring that every child across the globe has the right to engage in play activities. The United Nations also protected the development of children by declaring that,

"Every child has the right to a standard of living adequate for the child's physical, mental, spiritual, moral and social development. The state has a responsibility to assist parents and others responsible, and to provide material assistance where necessary, particularly for nutrition, clothing and housing" (Article 27).

More specifically to an African context, the African Charter on the Rights and Welfare of the Child (1990) was created because many felt that the United Nation's Convention on the Rights of the Child was not specific enough to cultural challenges faced in Africa. It was declared that;

"States recognise the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts; States shall respect and promote the right of the child to fully participate in cultural and artistic life and shall encourage the provision of appropriate and equal opportunities for cultural, artistic, recreational and leisure activity" (Children's Rights Project, 2000, p. 227).

These two documents, one international and one national, protect the rights of children, and specifically include their rights to develop in good conditions and their rights to engage in play activities. The question then arises as to whether these rights are being met. It is easy to propose documents and charters that claim to protect these rights, but how easy is it to protect these rights in practice and ensure that they are being granted across the country?

Factors that Inhibit Children from their Right to Play:

There are various outside factors that prevent children from developing properly and from engaging in play. “The reasons for this are poverty and few resources and in urban areas there is limited space to build recreational facilities like sports fields. Communities cannot afford to build their own sports facilities. Violence and crime also contribute towards children not being able to use these rights” (Children’s Rights Project, 2000, p. 227). The facilities where many children would play in South Africa are either non-existent, in disrepair, or dangerous. OT1 said that “South Africa does not have enough public facilities that encourage play. The public facilities that do exist are dangerous and in disrepair. They’re not economically and specifically built to stimulate kids. They need to change and create spaces for kids to play publicly” (OT1, personal communication, March 2012). She blamed the lack of facilities on the government and said that the “government needs to invest more in public spaces, through better equipment, more spaces, and more diversity in these spaces. They need to build different types of spaces, with diversity in the activities children can participate in. There need to be both gross and fine motor activity spaces” (OT1, personal communication, March 2012). The government can create charters and documents declaring that children have the right to play, but how are they actually facilitating play for their children? While the lack of play facilities may be one inhibiting factor

for children engaging in play, there is another factor very specific to South Africa standing in the way of play and proper development for children.

HIV in Children:

In the country there are, “Over 5.4 million South Africans...estimated to be living with HIV and AIDS” (Giese, 2009, p. 13). When focusing solely on children, the number is also astonishing, UNICEF estimated that 330,000 children (0-14) were infected with HIV in 2009 in South Africa (UNICEF, 2009). This is an epidemic that has been sweeping the nation for years, without much of an end in sight. The introduction of antiretroviral (ARV) treatment certainly aided those living with the disease, but the new infection rate is still rising. A good indicator of this is the percent of women in antenatal clinics who test positive. KwaZulu-Natal had the “highest proportion of adolescent girls aged 15-19 years visiting antenatal clinics who tested HIV positive” of 9 provinces. The rate was 22%” (Giese, 2011, p. 6) in 2009. South Africa is also facing an entirely different problem with this generation of children growing up. They are the first generation of young people in which some of them have grown up taking ARVs for the majority of their lives. They have been living with this disease and its negative repercussions for most of, if not all, of their lives. HIV affects individuals in 4 stages, each more serious than the previous. The stages of HIV are as follows;

“Stage 1: No symptoms of any illness, can last from 6-11 years (CD4 cell count +500), Stage 2: Mild disease, first signs of immune system weakening, minor complications, e.g. Weight loss, coughs, colds, etc (CD4 cell count -500), Stage 3: Moderate disease, e.g. chronic diarrhea, lasting fevers, thrush, TB (CD4 count -350), Stage 4: Severe disease, Acquired Immune Deficiency Syndrome, more than 30 different conditions including cryptococcal meningitis, pneumonia,

kaposi's sarcoma, life threatening (CD4 cell count <200)" (Salvation Army-Masiye Camp, p. 79).

As of recently, all children are required to take ARVs, regardless of their CD4 count. With treatment, among other things like physical activity and good nutrition, children can live long lives. These children do have to face opportunistic infections that arise from the disease and other health complications, including, but not limited to; "wasting syndrome, a failure to thrive typically due to gastrointestinal problems; recurrent bacterial infections, pulmonary syndromes, neurological syndromes, such as developmental delays and behavioral abnormalities; dermatitis; and other opportunistic infections" (Hussey, 2001, p. 350-351). The effects of terminal illness can also spread and lead to complications in other areas of a child's life. When a child understands that they are facing a terminal disease, such as HIV, the "realization typically leads to a separation from peer group members, depression (typically 6 months-1 year), and finally acceptance" (Schreier, 2001, 547). Once the child learns of their positive status they are faced with both physical and psychological health burdens.

How HIV Prevents Children From Playing:

The opportunistic infections and other health complications that children who are HIV-positive face are a huge inhibiting factor in their ability to play. Depending on the severity of the disease, and what stage they are in, their play opportunities can range from typical behavior consistent with children who are HIV-negative, to greatly inhibited if they are in a later stage of the disease. Children who have rapidly progressed through the stages of the disease from a very early age "tend to be very clingy, and haven't reached developmental milestones. They don't know how to socialize very well, because they have mostly been isolated in hospitals and have often been too sick to play" (OT1, personal communication, March 2012). Many spend most of

their lives in hospitals and clinics, and these spaces are not designed to meet the developmental and play needs of children.

“The current situation in KwaZulu-Natal is far from ideal. The existing health care system does not recognise children’s special social and emotional needs particularly in the case of young children (under 12 years). This is true at all levels of service delivery: PHC through Health centres and clinics, second level hospitals and tertiary/academic hospitals. The medical support personnel are not adequately trained nor equipped to attend to all aspects of children’s needs. When hospitalised, children in wards are left on their own for long periods - frightened, confused and bored. There is insufficient space, existing space is not optimally utilised and even children’s most minimal needs for intellectual stimulation, social interaction and emotional first aid are not met” (Children’s Rights Centre, nd, p.1).

A child who spends most of their early years in a hospital bed will not be able to develop on a typical track, such as the one described earlier, and more specifically will not be able to develop through play. Their physical developmental needs will not be met because they have limited space in which they can move about, many are confined to beds. Their psychosocial development will not be fostered because they will have limited interactions with others, whether they be peers or adults. Most of their interactions will come in the form of receiving medication from nurses, and possibly interacting with family who visits or other patients. Finally, cognitive development will lag as well because they will not be able to access toys or resources that could stimulate them cognitively, coloring books or blocks could be an example of this.

HIV-positive children face stigma from other children and parents who may be aware of their status. There are rights to protect HIV-positive children from discrimination and early disclosure;

“Basic rights of children infected with HIV are, right to non-discrimination and equality-no child with HIV or Aids may be unfairly discriminated against. Right to basic health care-young children with HIV/Aids have a right to be cared for when they are sick as a result of having HIV...Right to confidentiality of HIV test results-A child that is 14 years or older can consent to an HIV test without getting permission from his or her parents. This child also has the right to keep the result of the test private. Nobody has to the right to tell the child’s parents the result of the test without the child’s permission. A school does not have the right to demand to know whether a child has HIV. It is up to the parent or guardian to decide whether to give the school this information” (Children’s Rights Project, 2000, p. 116).

Again, these rights were put in place by the South African government, to protect children against stigma surrounding HIV positivity, but are these rights actually being granted? While living in the rural area of Amatikulu, I spoke with a community care giver on the issue of discrimination against children living with HIV. She told me that “it’s not usually the children who will discriminate, it’s the parents who will not allow their children to play with children they know are HIV-positive” (CCG1, personal communication, March 2012). The South African government claims that it is an HIV-positive child’s right to non-discrimination, but it is unclear as to how they expect to monitor this and ensure that it happens. There is also the issue of disclosure. Many parents are afraid to get their children tested, because many feel a great burden of guilt that they may have infected their children. Ramugondo said, “if the mother hasn’t even disclosed to her own partner about her own HIV status, the fear around exposing the child to possible detection is very real, so the child may then be kept away from others” (Ramugondo, personal communication, April 2012). This therefore becomes a barrier in their play development because children who are HIV-positive, or even suspected of being so, are not always allowed to play with others and build crucial early relationships, because of the fear the

parent has of their status being disclosed or because they are discriminated against by other parents or children who are aware of their positive status.

Finally, HIV-positive children also face another barrier when trying to engage in play. Ramugondo brought up the point that, “there might also be the whole notion of the dying child” (Ramugondo, personal communication, April 2012). Though ARVs are helping many children in South Africa live long, healthy lives, there is still a large portion of children who cannot access the medication for various reasons, including transport, distance of the nearest clinic, unwilling caregivers, etc. “At the end of 2010, an estimated 55 percent of people who needed it were receiving treatment for HIV, according to the latest WHO guidelines” (Avert, 2011). Those who cannot get access to needed treatment are in serious danger of the disease progressing very rapidly, especially children. Parents can sometimes look at a child with HIV as simply a dying child, who won’t live past the age of four (the rough life expectancy of a child living with HIV who is not on treatment (Ramugondo, personal communication, April 2012)). It is therefore hard for a parent to understand that they still need to engage with the child and play with them. “It’s very easy to get to a point where the mother is really just waiting for the inevitable. What do you do when you are told that your child is not going to live beyond 4? What are the chances for play for the child? They are just waiting” said Ramugondo (personal communication, April 2012). If caregivers do not foster play opportunities for the child, they will not be able to engage in activities and their development will lag behind. It is also important to consider the psychosocial effects this will have on the child. If they are constantly viewed as a dying child rather than a thriving one, they will also feel that they have no purpose to live and will not actively seek friends and build peer relationships that are critical to their psychosocial development.

Measures Being Taken To Foster Play:

The lack of opportunities for play for children, especially those living with HIV, is a serious problem in South Africa, but is anything being done to correct this? The Children's Rights Centre in Durban does a lot of work to protect the rights of children across the country. They work both with government and on a grass-roots level to ensure that the rights of children are granted. Their play department, headed by Sharon Shevil and Ramila Fakir focuses specifically on the play rights of children. Work has been done by the department to set up play centers in hospitals in KwaZulu-Natal to encourage children to play, in whatever way they can, while hospitalized. One program that had a great amount of success was the the Hospital Play People Programme at King Edward VIII Hospital. It started in 1988 through the work of Sharon Shevill and the Union of Jewish Women, and was taken under the direction of the CRC in 1994. A mobile, lockable cupboard of toys was donated to the pediatric ward of King Edward VIII Hospital in Durban. Play People volunteers would go into the children's wards for a few hours each day and engage with the children in play activities, everything from large group games to just stimulating the child with a toy (Shevil, personal communication, April 2012).

Unfortunately, as with many play center programs, Shevil stated that, "It's always the funding that makes these play programs go under. People always want to donate toys, but it's not the toys we need, it's the volunteers and the money to transport the volunteers. The programs aren't sustainable if they don't have volunteers. We tried to give the volunteers money for transport and food, because they're not getting any other money, but we just didn't have the funds for it" (Shevil, personal communication, April 2012). The program went under, because there was not enough support and funding to sustain it.

The funding needed to keep the Play People program running could have come from the South African government, but did not. OT1 believes there is a need for government support to

foster play and “invest in the children” (OT1, personal communication, March 2012). There are not enough public spaces for children to play and if they do exist, they are often in disrepair.

“The government needs to build play spaces, youth centres, and the government needs to pay for facilitators to work at the centres. The government needs to reinvest in children, and then children living with HIV can play too” (OT1, personal communication, March 2012).

Ramugondo had similar feelings, in which she believes that municipalities really need to come together and create more spaces and opportunities for children to play. She said that “I think there may be attempts. I have been in such a think tank, organized by government across different municipalities for development, education, health, for us to start having a conversation. As far as things go, it’s still conversation, and reflection, and asking questions. It’s not yet tangible action” (Ramugondo, personal communication, April 2012). There are policies in place that should be allowing children with HIV to play and develop, but government does not seem to be taking any concrete action towards making these policies a reality.

Conclusion:

Play is an absolutely crucial element to childhood development. It spans all areas of development; physical, psychosocial, and cognitive. Children who do not engage in play fall behind their peers developmentally, and suffer repercussions from this later in life. Though it seems easy to allow a child to play, there are many barriers preventing children from playing even though there are laws in place to protect them and to foster their play. In South Africa some children face a huge barrier preventing them from playing; HIV. A positive status can potentially bring opportunistic infections, discrimination, and parental guilt upon a child, all of which are barriers to play. Government says that there are policies and laws in place to prevent this from happening, as children have the rights to develop, play, and non-discrimination due to HIV

status, but these rights are not always met. This is a serious cause for concern. Children are unable to develop properly if they cannot play. Play and development are strongly tied together, and many children living with HIV are not able to engage in play activities to foster typical development. South Africa is still only talking about how to make play better for children, specifically those with HIV, but they have yet to take much action.

Recommendations for Further Study:

More research should be done concerning the specific developmental concerns for children living with HIV because of their lack of participation in play. It was generally stated that they will experience various physical, psychosocial, and cognitive delays, but it was not explored as to how these delays would present themselves. It would also be interesting to watch the children as they mature, to see if the developmental delays present themselves immediately or gradually throughout the lifespan, and would they be apparent delays or would they be subtle?

There should also be more research done on play programs that have been implemented across South Africa, and their success rates. It would be interesting to see if there was a common theme for their successes or failures across the country. More research could also be done around government's role in facilitating play for children. It is known that there are policies and laws in place to protect play for children, but one could further research what tangible actions they have tried to take to make play more accessible for children, specifically those with HIV. This research could also draw upon records of meetings that have been held by government concerning this topic, if there are any.

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Appendix 2: OT1 Interview, March 30, 2012

1. How important do you think play is in a child's development?

Of course play is essential for development. In the West we look for physical and social developments, but in Africa we see different sorts of play, different toys are used to different reasons, and hence as OTs we talk about physical performance and components, and these are different from a Western model in Africa. It's essential to development, but cultures influence play based on the cultural importance of play. Chores and housework are more important in rural areas, and play then becomes infused with chores because it's a common task in their lives. The value of play in different cultures is very different, children's roles influence the types of play. In Western culture more toys and tools are available for play, while in Africa there is more made-up play, using household items and non-manufactured play goods. This therefore changes the types of play.

2. What play activities do children typically engage in in South Africa?

Urban children in South Africa participate in most everything that Western children do. Based on their socioeconomic status, they can have all the toys and technology that Western children do. As we go to lower socioeconomic statuses and farther away from cities, types of play change and what they play with as well. Spaces that children play in implicate how they will play and what they will play with. Context and space have a huge implication on play.

3. Do you think play is valued as an important aspect of a child's life?

How educated parents are or what their socioeconomic status brackets are, influences the importance they place on play for their child's development. An educated parent knows how important it is. They can also choose the schools they send their children to, and choose schools that allow for play during the school day. Working parents aren't necessarily facilitating play, but they are allowing it to happen based on their school choices for their children. Parents in rural areas may direct their child's play more, as there will be specific times for play and times for chores during their days.

4. What inhibiting factors exist that prevent a child from engaging in play activities in South Africa?

South Africa does not have enough public facilities that encourage play. The public facilities that do exist are dangerous and in disrepair. They're not economically and specifically built to stimulate kids. They need to change and create spaces for kids to play publicly. Kids from lower socioeconomic statuses don't have the economic resources to buy play goods, and their lives also follow a different structure. This is a barrier to play for children from lower socioeconomic statuses. They may have different caregivers from day to day, and they don't know about any play resources or spaces.

5. Do you think that children living with HIV have a more difficult time engaging in play activities? Why?

One needs to look at the three categories of progression; rapid progressors, intermediate progressors, and longterm nonprogressors. Rapid progressors tend to be very clingy, and haven't reached developmental milestones. They don't know how to socialize very well, because they have mostly been isolated in hospitals and have often been too sick to play. For intermediate and longterm nonprogressors, HIV isn't much of a problem, except when they may be having a physical episode, like an illness or opportunistic infection. Typically, they play normal otherwise. I haven't seen stigmas causing a problem in play. That could be because of the cliental I see, because they're just typically engaging in play. For me, the kids I see in the hospice, they have the same joys and tragedies around play as most kids do.

6. What measures need to be taken to ensure that children, regardless of circumstances or diseases, can engage in play activities?

Two things mainly, the government needs to invest more in public spaces, through better equipment, more spaces, and more diversity in these spaces. They need to build different types of spaces, with diversity in the activities children can participate in. There need to be both gross and fine motor activity spaces. Socialization opportunities in park spaces need to be built as well. The government needs to build play spaces, youth centres, and the government needs to pay for facilitators to work at the centres. They have these spaces built already, but they're in terrible disrepair, with bad equipment. The government needs to reinvest in children, and then children living with HIV can play too. There is one space built for disabled children, but it is always kept under lock and key. This needs to be changed. Second, the focus of play in preparatory programs needs to be amped up. Training of preschool coordinators needs to be better in terms of

facilitating play. If the government started big preschool programs, a lot of money could be spent on resources there. Play needs to be built into preschool programs more. The government needs to really emphasize it and ensure that it is being done. They need to invest in the children.

Appendix 3: Elelwani Ramugondo Interview, April 19, 2012

1. How important/crucial do you think play is to a child's development?

I mean, you're explaining it in a way that pushes me to link it to development. I see play as all encompassing, and play as development as just one. It's just one part of it. Children play for different reasons and what I find very helpful is identifying rhetoric in play, what we value it for and consequently what we see in it. That play for development reflects a rhetoric as play for progress. That children play in order to development, so that they are like us, adults, which is important as well, but it's not all what play is about. There are other rhetorics. Once you are familiar with them you begin to value play for many reasons. Play for identity, for instance, in the community people see themselves playing in a particular way, it makes them who they are. Play as self, an expression of who the individual is, a child or an adult. Play as imaginary, it doesn't have to be tangible. It doesn't always have to do with development, there's really a lot I see in play, it's very voluntary. There's maybe something to just letting go, and in that respect, to me, any child who lacks in play engagement, is robbed of a critical human experience. Children who are HIV positive are limited from play engagement for different reasons. In my experience, what I saw, was children who were born infected through vertical transmission, the mother usually being the primary caregiver, often there are heavy emotions that the mother might carry, including possible guilt. There might also be the whole notion of the dying child. Parents, not so much now, because ARVs are increasingly available for children, but not 100%, probably 50% or in that region children who should be on ARVs, but aren't. If a child is born HIV-positive, what parents are told is the the child could only live up to 4 years and with children who have a high viral load, they start showing serious conditions quite early on. The opportunistic infections start showing up quite early. So, it's very easy to get to a point where the mother is really just

waiting for the inevitable. What do you do when you are told that your child is not going to live beyond 4? What are the chances for play for the child? They are just waiting. So, my work, when I was involved directly with the caregivers, involved reorienting how the child is perceived, from a dying child, to a playful being. So, as a mother they can get to a point where they can look back and say that my child's life was worth living. You also can't just stop working with the child.

You do need to get close to the mother, what is she confronted with? What are the issues she faces? It is a conversation that you can enable as an OT. When the mother begins to tell her story and feel listened to, then their whole experience as a mother comes forward, and then as an OT you can start asking questions about the child, to someone who feels ready to talk. Even just simple questions like, what is your child's favorite toy, what do they laugh at, is there anyone that they really love to play with? Anything like that. It will change how the mother looked at their own child. It's a different kind of question. Usually it's just, did you give them the medication, is the child feeling well? It's really just OTs remembering that play is the primary occupation of childhood. We say that a lot, but whether we truly understand it and appreciate what it means is something else. We are very good at using play to reach therapeutic goals, but not very good at enabling play as an end goal, especially in context.

2. Do you notice any big differences between a Western and African model of play?

I think that it may not so much, "the African model of play", but it may just be a different context, and what they do to enable play and what is a barrier. Culture is such a dynamic thing. What is African? The world is so globalized. People are confronting more or less the same thing across continents and regions, but there is definitely the issue around how involved the adult is able to be. What are the barriers? What experiences have the adults themselves had about play. If

people have had opportunity to play in various forms when their own children are robbed of that they will pick it up, they will lament.

3. Do you also notice anything with stigma or discrimination from children or parents towards children with HIV?

Stigma is a real issue. There are also children, who may even be 10 years old, who do not know they are HIV positive. There's a lot of that. So, people may be suspicious, but may not be for sure, but may make indications that the child is not to be played with. Sometimes, it's with the parents themselves, if the mother hasn't even disclosed to her own partner about her own HIV status, the fear around exposing the child to possible detection is very real, so the child may then be kept away from others. What are the chances that someone will suspect? It is very real.

4. Do you see any work being done to help facilitate play?

The thing about government is that they can facilitate policy to be there. We have wonderful policy, the Child's Act. We also have policies on ECD, and play central, but government officials need to come and do the work, it's for everyone to get involved. Municipalities obviously do play a role in that if you have politicians that if they are able to bring people together and have them talking about the different contributions that they can make in order to implement the policy, then that's what they should do. I think there may be attempts. I have been in such a think tank, organized by government across different municipalities for development, education, health, for us to start having a conversation, and it was someone else who is not an OT, she said to people from municipalities that you actually, you need OTs in order to design inclusive playgrounds. As far as things go, it's still conversation, and reflection, and asking questions. It's not yet tangible action. I think as OTs we have a lot on our plates. There's lots of

possibilities and potential We need to ensure that we can make a difference. I didn't get to publish my work, and that's a problem. We need to actually get work done in communities. It hard to get papers that are easily publishable. That is starting to change now.

Appendix 4: ISP Application for Review of Research with Human Subjects

Fall Semester 2012

School for International Training - Study Abroad

South Africa: Community Health, Program

Student to complete all questions, and anticipate probable issues and interactions before actual research begins. Submit this document and related documents to your Academic Director(s). Should you need to interview subjects that differ from the profile(s) below, you will need to provide details to the Academic Directors for further approval. Please make inserts in **BOLD**, and email to john.mcgladdery@sit.edu

ISP Details

1. Student's Name: **Rachel Bambrick**
2. Student Phone and E-mail: **0785606850** rbambri1@ithaca.edu
3. Title of ISP: **A Child's Right to Play While Living with HIV/AIDS in South Africa**
4. ISP Advisor Name, Title, and Contact Telephone: **Prof. Yousuf Vaudwa**,
VAWDAY@ukzn.ac.za

Human Subjects Review

1. Brief description of procedures relating to human subjects' participation:

a. Indicate proposed number of persons that may be participating per set

Experts-**8**

Academics-**3**

Minors-**Unknown, only based on observations**

Vulnerable Individuals-**Unknown, only based on observations**

Other - give descriptive details. _____

- b. Provide details of any cooperative institution? What is it, who is the contact, and how was their permission obtained? -**I will be working directly and cooperatively with the Children's Rights Centre. My gatekeeper to the centre**

is Sunitha Eshwarlall. I engaged with her via email, and she was the first person willing to take me on board to volunteer with the organization.

c. What will participants be asked to do, or what information will be gathered?

(Append

copies of interview guides, instructions, survey instruments, etc. where applicable).-**Participants that I talk to while working with the organization will be asked about what they do for the organization, what the organization does for the community, and what they think their role in advocating for children’s rights is. If I am to use their information, I will give them a written consent for. Participants that I talk to who are experts in the field will be interviewed using a set of questions regarding my topic, which will be written up before the meeting. I will give them a written consent form prior to the interview. All other interactions will be based on observations from living in various communities and observing children engaging in play activities or from observing the on goings in the Children’s Rights Centre.**

d. Reciprocity – what is being given back to each participant?-**The participants will not be receiving any monetary value for participating in my project. They will be helping me because they want to and consented to it. If at any point they choose to retract their statements, they will be able to do so. _____**

2. Protection of human subjects. Before completing this section, you must read and agree to comply with the SIT Study Abroad Statement of Ethics. Even if no research is being done it is STILL incumbent on any person volunteering or learning to ensure no harm might be done.

a. Have you read and do you agree to comply with the World Learning Ethics Statement noted above?

Yes/No

b. Identify and indicate whether any participants risk any stress or harm by participating in this Study Project? If there is even a slight possibility, should this

research go ahead? Why? How will these issues be addressed? What safeguards will minimize the risks? *(Even if you do not anticipate any risks, explain why)*-

While volunteering with the Children's Rights Centre I will be mainly working with experts in the field and doing expert interviews, but while working with an organization I run the risk of including sensitive information about how the NGO runs. I will write up my practicum as a confidential section, and only publish the social science part of my paper. I also may work with the organization and visit play centres the NGO has set up for children in the hospital. I would not be interviewing the minors, but rather observing. I would keep any names completely confidential while writing up my observations.

- c. Who might you need written consent from? *(If nobody explain why)*- **I would need a written consent form while interviewing workers at the CRC and I would need a written consent form if I were to be able to interview any parents I encounter while observing play centres with the CRC. I will also need a written consent form when interviewing Occupational Therapy professors.**_____
- d. Indicate whether any participants are minors or not likely to understand consequences of participation? If there are, how will they be protected, and who will ensure their rights are protected?-**I will not be interviewing minors, only observing. In writing about my observations all names will be confidential (Child1, Child2, for example).**
- e. Will you ask questions of any persons who may appear unable to negotiate freely? How will you protect them from feeling coerced? *(If no, explain why all are freely abled)*- **I will mainly only be interviewing workers at the CRC, who are experts in their field and Occupational Therapy professors at local universities. On the chance that I am able to interview individuals in the**

community while visiting play centres set up by the CRC I would only interview parents, and only upon their written consent.

Human Subject Protection Essay:

While conducting my ISP I will follow every guideline to ensure that the rights of participants are fully protected. As I will be writing both a practicum and social science paper, I will protect both the individuals and organization that I work with. The interactions that I have with minors, various members of the communities that I have lived in, and workers at the Children's Rights Centre will be anonymous and names will be coded. I will not attach any names to the data concerning children, community members, and CRC workers. The only case in which I will attach names to data will occur when quoting expert interviews. The expert individuals that I interview will each be given a consent form, written in or translated to their native language. If the subject chooses to be identified, and I was not originally planning on identifying them, they will be given a consent form to fill out as well.

When working with minors all of my data collected will be based solely on observation. Names will not be included, only codes, such as "Child1, Child2", etc. The same will be done for community members and workers at the CRC, when quoting them directly.

As I will be keeping most of the primary data private, a coding sheet will be used to protect the real names of individuals. This coding sheet will be kept separately from my published ISP, and will not be published in any way. It will be destroyed once I hand in my ISP. The coding sheet will be a written document kept completely separately from my ISP saved on my computer.

If the data is to be used in the future, participants will still be kept anonymous and will be notified before the data is published elsewhere. They will be informed before the data is used again.

While conducting my ISP I will be working directly with the Children's Rights Centre. Before volunteering with the centre for the month of April I will fill out a written volunteer contract with the organization. I will work with the program director to work through my conditions of access with the organization.

As I write my practicum portion of the ISP I will refrain from criticizing the organization, and if I do have any critiques they will be done in the most tactful way possible. In order to further protect the rights of the organization I will keep the practicum portion of my ISP

confidential and will not publish it. This will ensure that the intricate goings on of the organization will be kept private and will not be published. I may encounter rather sensitive information while closely working with the centre, and do not want to offend them in any way. Therefore, the practicum portion of my ISP will not be published or distributed.

4. Participant observation situations; Declaration:

When participating in an organization or community I will:

- a. Undertake a bilateral negotiation with the group I am participating with.*
- b. Work with gatekeepers to assist in that negotiation and draw up a contract with that gatekeeper, defining roles and conditions of access.*
- c. Work with the gatekeeper to communicate that contract with the group.*
- d. Refrain from criticizing and intervening unless invited by the gatekeeper in consultation with the group, and even then with due tact and caution.*

By signing below I certify that all of the above information is true and correct to the best of my knowledge, and that I agree to fully comply with all of the program's ethical guidelines as noted above and as presented in the program and/or discussed elsewhere in program materials. I further acknowledge that I will not engage in ISP activities until such a time that both my ISP proposal as well as my Human Subjects Participation application are successful and I have been notified by my Academic Director(s) to this effect.

Rachel Bambrick
Student's name (signature)

Rachel Bambrick
Student's name (printed)

Date: **March 26, 2011**

**Human Subjects Review Action Form
For Office Use Only**

Student Name: _____

Proposed ISP Title: _____

Program: _____

Semester and Year: _____

ACTION TAKEN:

- Approved by AD(s) and/or ISP Advisor as submitted
- Approved by AD(s) and/or ISP Advisor pending revisions (revise and resubmit)
- Disapproved by AD(s) and/or ISP Advisor
- Requires ERB review

*Please note hard copies of this form, the ISP proposal, and related correspondence are to remain filed in the program office for a duration of (no less than) one semester following completion of the ISP.

ATTACHMENTS INCLUDED AS APPROPRIATE (CHECK ALL THAT ARE ATTACHED):

- ISP/ISP Proposal (Reqd)
- Written Informed Consent form/s for adults (Reqd)
- SIT Human Subjects Policy (Reqd signed)
- Human Subjects Application and Essay (Reqd)
- Other(s) (please specify): _Question Template?

Appendix 5: Human Subject Consent

Written Consent:

1. OT1, name changed.
2. Karlsson, J., name kept.
3. Bambrick, R., name kept.

Oral Consent:

1. Shevil, S., name kept.
2. Ramugondo, E., name kept.
3. CCG1, name changed.

Appendix 6: Consent Form For Adult Respondents in English

I can read English. (If not, but can read Zulu or Afrikaans, please supply). If participant cannot read, the onus is on the researcher to ensure that the quality of consent is nonetheless without reproach.

*I have read the information about this study project and had it explained to me, and I fully understand what it says. I understand that this study is trying to find out (**Learner to state objectives**): to learn more about child rights in South Africa, to learn more about play development in children, to learn more about the effects of HIV/AIDS on children, specifically with regards to play and development.*

I understand that my participation is voluntary and that I have a right to withdraw my consent to participate at any time without penalty.

*I understand and am willing for you to observe and take notes And ask me questions about : (**Learner to indicate what questions will be asked**)*

- Play development
- Children's play rights
- Effects of HIV/AIDS on children and their play
- Child rights in South Africa
- Inhibiting factors to play rights

*I do/ do not require that my **identity (and name)** be kept secret (**delete inapplicable**). I understand that, if requested, my name will not be written on any questionnaire and that no one will be able to link my name to the answers I give. If requested, my individual privacy will be maintained in all published and written data resulting from this study project.*

*I do/ do not (**delete inapplicable**), give permission for a **photograph** of me to be used in the writeup of this study or for future publication. I understand that the learner will not use or provide any photographs for commercial purposes or publication without my permission.*

*I understand that I will receive (learner to indicate what will be given)... or **no gift** or direct benefit for participating in the study.*

I confirm that the learner has given me the address of the nearest School for International Training Study Abroad Office should I wish to go there for information. (18 Alton Road, Glenmore, Durban).

I know that if I have any questions or complaints about this study that I can contact anonymously, if I wish, the Director/s of the SIT South Africa Community Health Program (Zed McGladdery 0846834982).

I agree to participate in this study project.

Signature (participant) _____ Date: _____

Signature (learner) _____ Date: _____